

Buncombe County
Community Child Protection Team & Child Fatality Prevention Team



Protecting our Children

**2024 ANNUAL REPORT TO THE BUNCOMBE COUNTY
BOARD OF COMMISSIONERS**
Submitted 04/25/2025

I. Introduction to the North Carolina Child Fatality Prevention System

North Carolina’s Child Fatality Prevention System is addressed in Article 14 of Chapter 7B of the North Carolina General Statutes. The public policy that anchors this system is articulated in the statute as follows: “The General Assembly finds that it is the public policy of this State to prevent the abuse, neglect, and death of juveniles. The General Assembly further finds that the prevention of the abuse, neglect, and death of juveniles is a community responsibility; that professionals from disparate disciplines have responsibilities for children or juveniles and have expertise that can promote their safety and well-being; and that multidisciplinary reviews of the abuse, neglect, and death of juveniles can lead to a greater understanding of the causes and methods of preventing these deaths.”

Session Law 2023-134 (the Appropriations Act of 2023) included revisions to Article 14 and other parts of state statute to restructure the state’s Child Fatality Prevention System “in order to eliminate the silos and redundancy that exist within the current system, implement centralized coordination of the system, streamline the system's State-level support functions, maximize the usefulness of data and information derived from teams that review child fatalities, ensure that relevant and appropriate information and recommendations from teams that review child fatalities reach appropriate local and State leaders, and strengthen the system's effectiveness in preventing child abuse, neglect, and death.” **Appendix 1 outlines some of the key revisions from a local perspective. While this restructuring began at the state level in 2024, changes to county-level teams will begin on July 1, 2025.**

According to the revised Article 14, “the purpose of the system is to assess the records of child deaths in North Carolina from birth up until a child’s eighteenth birthday, and with respect to these cases, to study data and prevention strategies related to child abuse, neglect, and death, and to utilize multidisciplinary teams to review these deaths in order to (i) develop a communitywide approach to the problem of child abuse and neglect, (ii) understand the causes and contributing factors of childhood deaths, (iii) identify any gaps or deficiencies that may exist in the delivery of services to children and their families by public agencies that are

designed to prevent future child abuse, neglect, and death, (iv) identify and aid in facilitating the implementation of evidence-driven strategies to prevent child death and promote child well-being, and (v) make and implement recommendations for changes to laws, rules, and policies that will support the safe and healthy development of children and prevent future child abuse, neglect, and death.”

In 2024 (and until July 1, 2025), every county in NC has two teams that are part of the state Child Fatality Prevention System.

1. The **Community Child Protection Team (CCPT)** reviews selected active cases of children who are being served by child protective services (CPS), and all cases in which a child died as a result of suspected or confirmed abuse or neglect and a report of abuse or neglect had been made about the child or their family to the Department of Social Services (DSS) within the prior 12 months, or the child or their family was a recipient of CPS within the prior 12 months.
2. The **Child Fatality Prevention Team (CFPT)** reviews the records of all cases of additional child fatalities (i.e., the deaths of children who died from a cause other than suspected abuse or neglect). It is important to note that fatalities are reviewed during the calendar year following the year of death.

In most counties, including Buncombe, these two local review teams are merged into one team. Based on case reviews, the local CCPT/CFPT makes recommendations and advocates for system improvements and needed resources where gaps and deficiencies may exist.

CCPT and CFPT membership is designated by statute, consisting of various representatives of public and private community agencies that provide services to children and their families, including the local Department of Social Services (DSS), Health Department, law enforcement, Guardian Ad Litem, and school systems. The local board of county commissioners also may appoint as many as five additional members to represent agencies or the community at-large. **Appendix 2 shows the mandated members and their appointing authority, as well as the specific individuals filling those roles for the Buncombe County CCPT/CFPT at the time of this report.**

The purpose of this report is to summarize the activities and accomplishments of the Buncombe County CCPT/CFPT during the prior calendar year, including the number of child fatality reviews conducted, data related to those fatalities, and recommendations for system improvements and needed resources to prevent child abuse, neglect, and death.

II. Role of the Buncombe County Board of Commissioners

- Receive the annual report from the Buncombe County CCPT/CFPT, which contains recommendations for prevention of child abuse, neglect, and death.
- Advocate for system improvements and needed resources, if requested.

- Appoint members to the Buncombe County CCPT/CFPT as designated by state statute.

III. Child Fatality Reviews

The Buncombe County CCPT/CFPT reviewed 20 deaths of children who resided in Buncombe County at the time of their deaths in 2023. **Please see Appendix 3 for data on the causes of child deaths in Buncombe County in 2023, as well as select demographic information about the deceased children.**

During review of the 2023 child fatalities, the team identified the following system problems, made recommendations to address those problems, and took the following actions.

Cause of Death	System Problem	Recommendation	Actions
Sudden Unexplained Infant Deaths	Paid family leave is associated with reductions in infant mortality but is something that many parents in the United States lack. (https://policylab.chop.edu/blog/we-know-paid-family-leave-saves-infant-lives-so-when-will-policymakers-catch)	The Buncombe County Public Health Director should advocate for paid family leave to be added to the NC Association of Local Health Directors' (NCALHD) legislative advocacy priority list. Buncombe County leadership should advocate for paid family leave to be added to the County's legislative priorities and potentially the NC Association of County Commissioners' legislative priorities.	The Buncombe County Health Director shared this recommendation with NCALHD leadership at the February 2025 NCALDH meeting. The BCHHS Director shared this recommendation with Assistant County Manager Sybil Tate in February 2025.
	Co-sleeping continues to lead to preventable infant deaths.	a) Buncombe County should move forward with plans to roll out a public campaign focused on infant safe sleep in October 2024. b) First Responders in Buncombe County should be trained on infant safe sleep so they can assess and provide guidance and resources to caregivers when responding to calls for service in the homes of families with infants. (<i>Local training was originally scheduled for October 2024 but was rescheduled to March 2025 due to Hurricane Helene.</i>)	a) Hurricane Helene disrupted plans for this campaign. The Team Chair will re-engage with the County's Community and Public Engagement Team in Spring 2025. b) In March 2025, the Team Chair shared information with Buncombe County first responder agencies about a training for first responders on preventing sleep-related infant deaths.

Suicide	Ongoing stigma about mental health is a barrier that prevents youth and families from addressing mental health conditions, leading to unnecessary morbidity and mortality, including in BIPOC and other marginalized populations.	The Buncombe County Community & Public Engagement (CAPE) Team & Buncombe County Children’s Collaborative, along with guidance and assistance from Vaya’s System of Care, should include efforts to break down mental health stigma as part of their mental health/suicide prevention campaign and should include stakeholders in BIPOC communities and other marginalized populations (like LGBTQ+ youth) in the campaign.	The Team Chair shared this recommendation with Jess Supik (Vaya Health’s System of Care Coordinator), Victoria Reichard (Buncombe County Behavioral Health Manager), and Stacey Wood (CAPE) in August 2024.
----------------	---	--	---

IV. Buncombe County CCPT/CFPT Activities and Accomplishments

- The full team met nine times in 2024 and an additional two times in 2025 to complete all required 2023 fatality reviews. Additionally, due to the cancellation of meetings because of holidays and Hurricane Helene recovery, a subcommittee of the team met once in November 2024 to review fatalities that had lower probability of involving system problems.
- The team allocated their FY24 state funding to the Buncombe County Community and Public Engagement (CAPE) Team to purchase signage promoting the 988 Suicide and Crisis Lifeline for display at Buncombe County Parks and other community locations.
- The Team Chair and Review Coordinator completed the required reports on each child fatality reviewed by the team and submitted these reports to the state CFPT Coordinator.
- The Team Chair completed the annual NC DHHS CCPT Survey and CFPT Activity Summary.

V. Conclusion

Several individuals transitioned off our team since submission of the last annual report. Thank you to Stoney Blevins, Jacquelyn Hallum, Dr. Deana Lashley, Max Boswell, Judge Ward Scott, and Tammy Cody for their years of service to our team and Buncombe County children and families.

Thank you to the members of the Buncombe County Board of Commissioners for this opportunity to share the work of the Buncombe County CCPT/CFPT. We appreciate your support of our efforts and your attention to our recommendations for the prevention of child abuse, neglect, and death. Please feel free to contact me should you have any questions about this report.



Jennifer Mullendore, MD, MSPH
Chair, Buncombe County CCPT/CFPT

Appendix 1: Highlights of Changes to North Carolina's Child Fatality Prevention System

NC Session Law 2023-134 (the Appropriations Act of 2023) revised state statute related to the NC Child Fatality Prevention System. The changes include the following:

- Establishment, funding, and staffing of a State Office of Child Fatality Prevention within the NC Department of Health and Human Services, Division of Public Health, to serve as the lead agency for child fatality prevention in North Carolina.
- As of 07/01/2025, ending of the current Child Fatality Prevention Team and Community Child Protection Team model for each county and transition to either a single county "Local Team" or a multicounty "Local Team" to review child deaths.
- Change in the categories of fatalities reviewed by "Local Teams"
 - The "Local Team" *shall* review all child deaths of resident children under age 18 in the county (or counties) that fall under one of the following categories of death:
 - Undetermined causes
 - Unintentional injury
 - Violence
 - Motor vehicle incidents
 - Deaths related to child maltreatment or child deaths involving a child or child's family who were reported or known to child protective services.* These reviews shall occur if any of the following criteria are met:
 - The decedent was known to be reported as being abused or neglected under NC General Statute (G.S.) 7B-301 regardless of the disposition of such report.
 - There was a known report involving child abuse or neglect under G.S. 7B-301 within the three-year period preceding the time of a child's death that involved the child's family regardless of the disposition of the report.
 - The decedent or decedent's family was involved with child protective services within three years preceding a child's death.
 - Available information indicates a possibility that child abuse or neglect, as defined in G.S. 7B-101, may be a direct or contributing cause of the child's death.

**Of note, there will no longer be state-led 2-day Intensive Fatality Reviews for this type of fatality. Instead, State Office staff will provide technical assistance to Local Teams which may include assistance with coordinating the review, information gathering, determination of necessary participants, meeting procedures and facilitation, development of recommendations, and drafting of reports.*

- Sudden unexpected infant death
- Suicide
- Deaths not expected in the next six months
- Additional infant deaths according to criteria established by the State Office in consultation with perinatal health experts and participants in reviews of infant deaths. The criteria shall consider leading causes of infant death, including short gestation, low birthweight, and perinatal complications, and shall be updated at least biannually based on emerging information and data.

- Each Local Team *may* review child deaths that fall outside the categories specified above.
- Permissive Review of Active Child Protective Services Cases – At the request of a local DSS Director, a Local Team may elect to review an active case in which a child or children are being served by child protective services. The Local Team is not required to make findings or create reports based upon such reviews. However, the Local Team may develop recommendations based on such reviews to be submitted to the citizen review panel serving the area in which the Local Team is located and may also include in its recommendations to the Board of County Commissioners.
- Changes in composition of local Child Fatality Prevention Teams
 - No longer includes “additional members” appointed by County Board of Commissioners.
 - Instead, the chair of the Local Team may invite a maximum of five additional individuals to participate on the Local Team on an ad hoc basis for a specific review if the chair believes the individual's subject matter expertise or position within an organization will enhance the ability of the Local Team to conduct an effective review. The chair may select ad hoc members from outside of the county or counties served by the Local Team.
- Transition to use of the National Fatality Review Case Reporting System (NFR-CRS)
 - NFR-CRS is a web-based system used by a majority of states to provide child death review teams with a simple method for capturing, analyzing, and reporting on the full set of information shared at a child death.
 - Training on this system is set to occur in August 2025 with use of the NFR-CRS starting January 1, 2026.
 - For each child death reviewed, the Local Team shall make findings addressing at least the following:
 - Significant challenges faced by the child or family, the systems with which they interacted, and the response to the incident.
 - Notable positive elements in the case that may have promoted resiliency in the child or family, the systems with which they interacted, and the response to the incident.
 - Recommendations and initiatives that could be implemented at the State or local level to prevent deaths from similar causes or circumstances in the future.
 - Whether the cause or a contributing cause of the death was related to child abuse or neglect.
- Establishment of at least three Citizen Review Panels across NC with volunteer members who are to evaluate the extent to which the state is fulfilling its child protection responsibilities in accordance with federal law. (Local CCPTs previously served as these panels.)

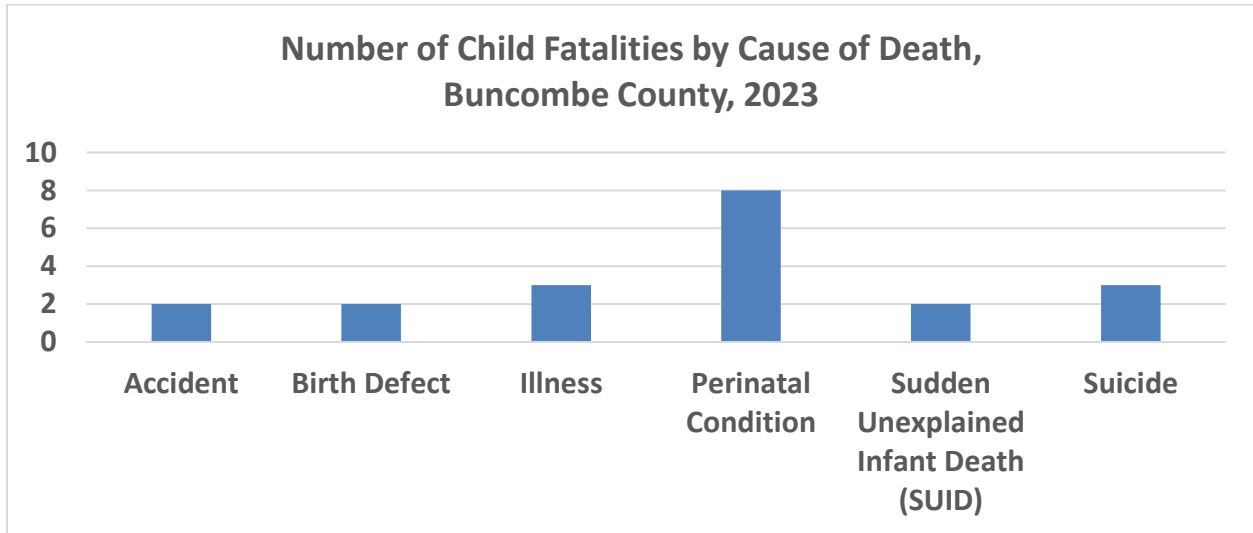
Appendix 2: Buncombe County CCPT/CFPT Membership (as of 04/25/2025)

MANDATED MEMBER	APPOINTING AUTHORITY	AGENCY	REPRESENTATIVE	MEMBER SINCE
DSS Director		Buncombe County HHS (BCHHS)	David Sweat	2024
DSS staff member		BCHHS	Rebecca Smith	2019
			Sherrie Thomas	2024
Local Law Enforcement Officer	Board of County Commissioners	Buncombe County Sheriff's Dept.	Sgt. Caleb Hunter	2022
Attorney from District Attorney's Office	District Attorney	Buncombe District Attorney's Office	David Denninger	2023
Executive Director of local community action agency (or their designee)		Community Action Opportunities	Trudy Logan	2016
Superintendent of each local school system (or their designee)		Asheville City Schools	April Dockery	2021
		Buncombe County Schools	Shanon Martin	2023
County Board of Social Services member	Chair of BCHHS Board	Buncombe County HHS Board	Kasee Locke	2025
Mental Health Professional	Vaya Health LME/MCO Director	Vaya Health	Angela Garner	2023
Guardian ad Litem Coordinator (or their designee)		Guardian ad Litem – District 28	Coby Wellshear	2019
Director of local Department of Public Health		Buncombe County HHS	Dr. Ellis Matheson	2023
Local Health Care Provider	BCHHS Board	Buncombe County HHS	Dr. Jennifer Mullendore	2011
		MAHEC OB/GYN Specialists	Dr. Carol Coulson	2023
		Mission Children's Specialists	Dr. Sarah Monahan-Estes	2024
Emergency Medical Services provider or firefighter	Board of County Commissioners	Buncombe County EMS	Sean Clickner	2025

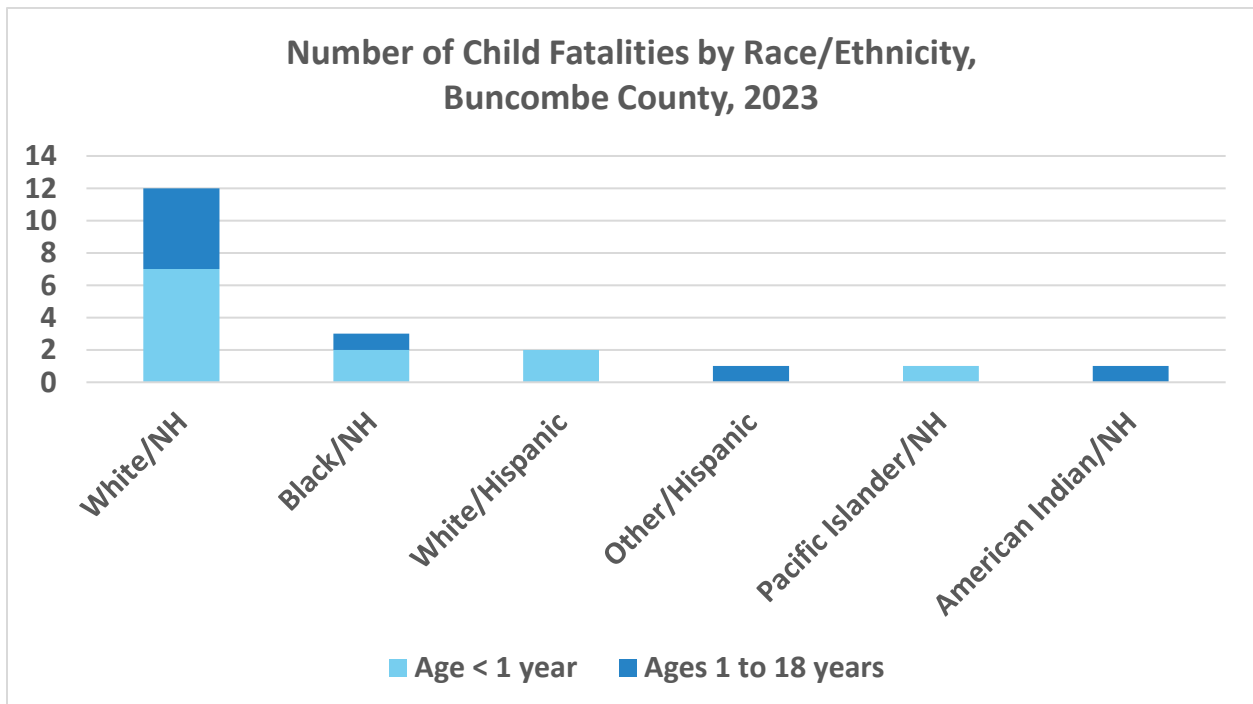
(Continued on next page)

District Court Judge	Chief District Court Judge	Buncombe County District Court	Judge Susan Dotson-Smith	2025
County Medical Examiner	Chief Medical Examiner	Buncombe County Medical Examiner	Paula Case	2022
Representative of a Local Childcare Facility or Head Start program	Buncombe County DSS Director	Community Action Opportunities Head Start	Sharon Farmer	2015
Parent of a Child Who Died Before 18 th Birthday	Board of County Commissioners	n/a	<i>vacant</i>	
Additional member #1	Board of County Commissioners	Children's Developmental Services Agency	Molly Payne	2005
Additional member #2		Mountain Child Advocacy Center	Colleen Burnet	2023
Additional member #3		Community Care of NC (CCNC)	Sherry Noto	2018
Additional member #4		Helpmate	Jordyn Dezago	2024
Review Coordinator	Buncombe County DSS Director and Health Director	BCHHS	Deana Shetley	2020

Appendix 3: 2023 Buncombe County Child Fatality Data (based on fatalities assigned to the Buncombe County Child Fatality Prevention Team)



- There were 20 fatalities in total, including 12 infants.
- The fatalities due to accidents involved anaphylaxis after exposure to a known allergen and a pedestrian hit by motor vehicle.
- The fatalities due to perinatal conditions involved five extremely premature births, two placental abruptions, and a home birth with complications.
- Both Sudden Unexplained Infant Deaths were categorized as having an undetermined cause but involved unsafe sleep environments and co-sleeping.



NH = non-Hispanic

- All fatalities by race/ethnicity:
 - 12 White/Non-Hispanic
 - 3 Black/Non-Hispanic
 - 2 White/Hispanic
 - 1 Other/Hispanic
 - 1 Pacific Islander/Non-Hispanic
 - 1 American Indian/Non-Hispanic
- Infant fatalities by race/ethnicity:
 - 7 White/Non-Hispanic
 - 2 Black/Non-Hispanic
 - 2 White/Hispanic
 - 1 Pacific Islander/Non-Hispanic
- All fatalities by gender:
 - 9 females
 - 11 males
- Infant fatalities by gender:
 - 4 females
 - 8 males

